Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS108AGC	A. BUILDING _____ B. WING _____	C 03/25/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLESTON RESIDENTIAL CARE HOTEL	2121 W CHARLESTON BLVD LAS VEGAS, NV 89102

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of complaint investigation conducted in your facility on 3/25/10. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for 129 Residential Facility for Group beds for elderly and disabled person and/or persons with mental illness. The census at the time of the survey was 125. Twenty five resident files were reviewed and ten employee files were reviewed. One discharged resident file was reviewed. Complaint #NV00024523 was substantiated See Tag Y878	Y 000		
Y 878 SS=E	449.2742(6)(a)(1) Medication / Change order NAC 449.2742 6. Except as otherwise provided in this subsection, a medication prescribed by a physician must be administered as prescribed by the physician. If a physician orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order.	Y 878		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 878	Continued From page 1 This Regulation is not met as evidenced by: Based on observation, interview and record review on 3/25/10, the facility did not administer medications as prescribed for 2 of 25 residents. Findings: The medication Nurse did not comply with the order and medications were missing. Interviews: The Administrator and the Medication Nurse stated that after repeated request, and calls, and faxes the doctors don't answer, don't return calls and the medications get delivered late to the facility. When resident families supply the medications they sometimes don't have the money to pay for the meds and they are late. Severity: 2 Scope: 2 Allegation was substantiated with deficiency.	Y 878		